FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044347

Facility Name: BLOOMINGDALE PAVILION

Address: 311 EDGEWATER DRIVE (Number) BLOOMINGDALE (City) 60108 (Zip Code)

County: DUPAGE

Telephone Number: (630) 894-7400 **Fax #** (630) 894-8528

IDPA ID Number: 364214316001

Date of Initial License for Current Owners: 05/01/98

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) MARVIN FOX, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds n/a

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	259	Skilled (SNF)	259	94,535	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	259	TOTALS	259	94,535	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	22,840	4,398	14,518	41,756	8
9	SNF/PED					9
10	ICF	30,389	5,778		36,167	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	53,229	10,176	14,518	77,923	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.43%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 5/1/98

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 5/1/98 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 259 and days of care provided 7917

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	338,056	25,142	13,868	377,066		377,066	20,071	397,137			1
2	Food Purchase		313,901		313,901	(32,850)	281,051	(409)	280,642			2
3	Housekeeping		26,981	246,027	273,008		273,008		273,008			3
4	Laundry		19,883	137,826	157,709		157,709		157,709			4
5	Heat and Other Utilities			233,075	233,075		233,075	1,821	234,896			5
6	Maintenance	91,299		109,072	200,371		200,371	(4,629)	195,742			6
7	Other (specify):*							3,934	3,934			7
8	TOTAL General Services	429,355	385,907	739,868	1,555,130	(32,850)	1,522,280	20,788	1,543,068			8
	B. Health Care and Programs											
9	Medical Director			28,375	28,375		28,375		28,375			9
10	Nursing and Medical Records	3,920,640	183,600	613,964	4,718,204		4,718,204	(23,596)	4,694,608			10
10a	Therapy	132,967	24,085	9,979	167,031		167,031	(910)	166,121			10a
11	Activities	194,099	20,006	2,632	216,737		216,737		216,737			11
12	Social Services	96,177		2,070	98,247		98,247		98,247			12
13	Nurse Aide Training											13
14	Program Transportation			373	373		373		373			14
15	Other (specify):*							5,693	5,693			15
16	TOTAL Health Care and Programs	4,343,883	227,691	657,393	5,228,967		5,228,967	(18,813)	5,210,154			16
	C. General Administration											
17	Administrative	147,227		561,521	708,748		708,748	(353,299)	355,449			17
18	Directors Fees											18
19	Professional Services			87,357	87,357		87,357	(15,124)	72,233			19
20	Dues, Fees, Subscriptions & Promotions			101,062	101,062		101,062	(55,622)	45,440			20
21	Clerical & General Office Expenses	190,074	48,567	325,791	564,432		564,432	(106,779)	457,653			21
22	Employee Benefits & Payroll Taxes			785,264	785,264	32,850	818,114		818,114			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,787	1,787		1,787	478	2,265			24
25	Other Admin. Staff Transportation			1,804	1,804		1,804		1,804			25
26	Insurance-Prop.Liab.Malpractice			178,861	178,861		178,861	26	178,887			26
27	Other (specify):*							57,336	57,336			27
28	TOTAL General Administration	337,301	48,567	2,043,447	2,429,315	32,850	2,462,165	(472,984)	1,989,181			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,110,539	662,165	3,440,708	9,213,412		9,213,412	(471,009)	8,742,403			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number BLOOMINGDALE PAVILION #0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			79,271	79,271		79,271	(22,887)	56,384			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			293,895	293,895		293,895	5,155	299,050			32
33	Real Estate Taxes			176,706	176,706		176,706		176,706			33
34	Rent-Facility & Grounds			1,148,847	1,148,847		1,148,847	17,496	1,166,343			34
35	Rent-Equipment & Vehicles			22,359	22,359		22,359	1,668	24,027			35
36	Other (specify):*			80,024	80,024		80,024	(5,066)	74,958			36
37	TOTAL Ownership			1,801,102	1,801,102		1,801,102	(3,634)	1,797,468			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	312,047	625,227	1,097,951	2,035,225		2,035,225	(104,398)	1,930,827			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			141,803	141,803		141,803		141,803			42
43	Other (specify):*	1,979		103,160	105,139		105,139	(105,139)				43
44	TOTAL Special Cost Centers	314,026	625,227	1,342,914	2,282,167		2,282,167	(209,537)	2,072,630			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,424,565	1,287,392	6,584,724	13,296,681		13,296,681	(684,180)	12,612,501			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(41,704)	30		9
10	Interest and Other Investment Income	(652)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(409)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(11,952)	21		18
19	Entertainment	(2,235)	21		19
20	Contributions	(800)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(213,939)	21		24
25	Fund Raising, Advertising and Promotional	(46,967)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(14,413)	20		28
29	Other-Attach Schedule	(191,940)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (525,011)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(159,170)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (159,170)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (684,180)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

BLOOMINGDALE PAVILION

ID# 0044347

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Consultant	$ (218)	43	1
2	COPE - IL COUNCIL	(4,550)	20	2
3	Marketing Salary	(1,979)	43	3
4	Nonallowable legal fees	(21,357)	19	4
5	Capitalized R&M	(5,567)	6	5
6	Bank Charges	(55,237)	21	6
7	Van Commuting Expense	(102,942)	43	7
8	Seminar Expense	(90)	24	8
9				9
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STATE OF ILLINOIS

Summary A

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				2,306			136			17,629		20,071	1
2	Food Purchase	(409)											(409)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			1,467			354						1,821	5
6	Maintenance	(5,567)		59	644		235						(4,629)	6
7	Other (specify):*				3,090			844					3,934	7
8	**TOTAL General Services**	(5,976)		1,526	6,040		589	980			17,629		20,788	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			22,847			9,041				(55,484)		(23,596)	10
10a	Therapy								(436)	(474)			(910)	10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*			3,751			1,942						5,693	15
16	**TOTAL Health Care and Programs**			26,598			10,983		(436)	(474)	(55,484)		(18,813)	16
	C. General Administration													
17	Administrative			123,034	(335,425)	(57,423)	74,353	(157,838)					(353,299)	17
18	Directors Fees													18
19	Professional Services	(21,357)		7,397		(7,626)	6,462						(15,124)	19
20	Fees, Subscriptions & Promotions	(65,930)		7,271		57	2,980						(55,622)	20
21	Clerical & General Office Expenses	(284,163)		103,938		15,881	57,565						(106,779)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(90)		208			360						478	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			24			2						26	26
27	Other (specify):*			30,818		519	25,999						57,336	27
28	**TOTAL General Administration**	(371,540)		272,690	(335,425)	(48,592)	167,721	(157,838)					(472,984)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(377,516)		300,814	(329,386)	(48,592)	179,293	(156,858)	(436)	(474)	(37,855)		(471,009)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(41,704)		15,663		2,560	594						(22,887)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(652)		3,851		1,963	(7)						5,155	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds			11,980			5,516						17,496	34
35	Rent-Equipment & Vehicles				1,250		418						1,668	35
36	Other (specify):*					(5,066)							(5,066)	36
37	TOTAL Ownership	(42,356)		31,494	1,250	(543)	6,521						(3,634)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(37,993)	(41,849)	(24,556)		(104,398)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(105,139)											(105,139)	43
44	TOTAL Special Cost Centers	(105,139)							(37,993)	(41,849)	(24,556)		(209,537)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(525,011)		332,308	(328,136)	(49,135)	185,814	(156,858)	(38,429)	(42,323)	(62,411)		(684,180)	45

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	QUALITY CARE MANAGEMENT	100.00%	$ 1,467	$ 1,467	15
16	V	6	REPAIRS AND MAINT.		QUALITY CARE MANAGEMENT	100.00%	59	59	16
17	V	10	SAL-NURSING		QUALITY CARE MANAGEMENT	100.00%	20,932	20,932	17
18	V	10	NURS SAL-M. CLARKE		QUALITY CARE MANAGEMENT	100.00%	1,915	1,915	18
19	V	15	EMP. BEN.-H.C.		QUALITY CARE MANAGEMENT	100.00%	3,751	3,751	19
20	V	17	ADMIN SAL-NON-OWNER		QUALITY CARE MANAGEMENT	100.00%	30,006	30,006	20
21	V	17	ADMIN. SAL.- A. SALTZMAN		QUALITY CARE MANAGEMENT	100.00%	5,092	5,092	21
22	V	17	ADMIN. SAL - B BENOUDIZ		QUALITY CARE MANAGEMENT	100.00%	16,773	16,773	22
23	V	17	ADMIN. SAL. - B. CLOCH		QUALITY CARE MANAGEMENT	100.00%	44,125	44,125	23
24	V	17	ADMIN. SAL. - B. TEITELBAUM		QUALITY CARE MANAGEMENT	100.00%	6,413	6,413	24
25	V	17	ADMIN. SAL - J. MEISELS		QUALITY CARE MANAGEMENT	100.00%	2,638	2,638	25
26	V	17	ADMIN. SAL. - STEVE VAN CAMP		QUALITY CARE MANAGEMENT	100.00%			26
27	V	17	ADMIN. SAL. - MIKE FILIPPO		QUALITY CARE MANAGEMENT	100.00%	17,987	17,987	27
28	V	19	PROFESSIONAL FEES		QUALITY CARE MANAGEMENT	100.00%	7,397	7,397	28
29	V	20	FEES,SUBSCRIPTIONS		QUALITY CARE MANAGEMENT	100.00%	7,271	7,271	29
30	V	21	CLERICAL & GENERAL		QUALITY CARE MANAGEMENT	100.00%	92,966	92,966	30
31	V	21	ACCTG SAL-B. LARIMORE		QUALITY CARE MANAGEMENT	100.00%	7,353	7,353	31
32	V	21	OFFICE SAL-M. CLOCH		QUALITY CARE MANAGEMENT	100.00%	3,619	3,619	32
33	V	24	EDUCATION & SEMINAR		QUALITY CARE MANAGEMENT	100.00%	208	208	33
34	V	26	INSURANCE		QUALITY CARE MANAGEMENT	100.00%	24	24	34
35	V	27	EMP. BEN.-GEN. ADMIN.		QUALITY CARE MANAGEMENT	100.00%	30,818	30,818	35
36	V	30	DEPRECIATION		QUALITY CARE MANAGEMENT	100.00%	15,663	15,663	36
37	V	32	INTEREST		QUALITY CARE MANAGEMENT	100.00%	3,851	3,851	37
38	V	34	OFFICE RENT-UNRELATED		QUALITY CARE MANAGEMENT	100.00%	11,980	11,980	38
39	Total			$			$ 332,308	$ * 332,308	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	EQUIPMENT RENTAL	$	QUALITY CARE MANAGEMENT	100.00%	$ 1,250	$ 1,250	15
16	V								16
17	V	17	CORPORATE ALLOCATION	335,425	QUALITY CARE MANAGEMENT	100.00%		(335,425)	17
18	V								18
19	V	6	REPAIRS AND MAINT.	5,668	QUALITY CARE MANAGEMENT	100.00%	6,312	644	19
20	V	7	EMP. BEN.-GEN. SERV.		QUALITY CARE MANAGEMENT	100.00%	1,036	1,036	20
21	V								21
22	V	1	DIETICIAN SALARIES	10,208	QUALITY CARE MANAGEMENT	100.00%	12,513	2,306	22
23	V	7	EMP. BEN.-GEN. ADMIN.		QUALITY CARE MANAGEMENT	100.00%	2,054	2,054	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 351,301			$ 23,165	$ * (328,136)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMIN SAL-NON-OWNER	$	QUALITY CARE MANAGEMENT	100.00%	$ 1,465	$ 1,465	15
16	V	17	ADMIN. SAL. - B. CLOCH		QUALITY CARE MANAGEMENT	100.00%	4,685	4,685	16
17	V	17	ADMIN. SAL. - B. TEITELBAUM		QUALITY CARE MANAGEMENT	100.00%	3,319	3,319	17
18	V	17	ADMIN. SAL - J. MEISELS		QUALITY CARE MANAGEMENT	100.00%	1,366	1,366	18
19	V	19	PROFESSIONAL FEES		QUALITY CARE MANAGEMENT	100.00%	374	374	19
20	V	17	MGNT FEES-DIRECT ALLOC		QUALITY CARE MANAGEMENT	100.00%	157,838	157,838	20
21	V	20	FEES,SUBSCRIPTIONS		QUALITY CARE MANAGEMENT	100.00%	57	57	21
22	V	21	CLERICAL & GENERAL		QUALITY CARE MANAGEMENT	100.00%	15,881	15,881	22
23	V	27	EMP. BEN.-GEN. ADMIN.		QUALITY CARE MANAGEMENT	100.00%	519	519	23
24	V	30	DEPRECIATION		QUALITY CARE MANAGEMENT	100.00%	2,560	2,560	24
25	V	32	INTEREST		QUALITY CARE MANAGEMENT	100.00%	1,963	1,963	25
26	V	36	GAIN ON SALE OF ASSETS		QUALITY CARE MANAGEMENT	100.00%	(5,066)	(5,066)	26
27	V								27
28	V	17	CORPORATE ALLOCATION	226,096	QUALITY CARE MANAGEMENT	100.00%		(226,096)	28
29	V	19	COMPUTER SERVICES	8,000	QUALITY CARE MANAGEMENT	100.00%		(8,000)	29
30	V								30
31	V	1	DIETICIAN SALARIES		QUALITY CARE MANAGEMENT	100.00%			31
32	V	7	EMP. BEN.-GEN. ADMIN.		QUALITY CARE MANAGEMENT	100.00%			32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 234,096			$ 184,961	$ * (49,135)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	$ 354	$ 354	15
16	V	6	REPAIRS AND MAINT.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	235	235	16
17	V	10	NURSING		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	1,200	1,200	17
18	V	10	SAL-NURSING-M. CLARKE		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	7,841	7,841	18
19	V	15	EMP. BEN.-H.C.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	1,942	1,942	19
20	V	17	ADMIN SAL-NON-OWNER		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	17,675	17,675	20
21	V	17	ADMIN. SAL.- F. BENJAMIN		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	13,978	13,978	21
22	V	17	ADMIN. SAL - B BENOUDIZ		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	10,073	10,073	22
23	V	17	ADMIN. SAL. - B. CLOCH		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	11,823	11,823	23
24	V	17	ADMIN. SAL. - C. ROSS		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	1,401	1,401	24
25	V	17	ADMIN. SAL - S. VAN CAMP		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	8,693	8,693	25
26	V	17	ADMIN. SAL. - M. FILIPPO		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	10,710	10,710	26
27	V	17	ADMIN. SAL. - J. ELOWE		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%			27
28	V	19	PROFESSIONAL FEES		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	6,462	6,462	28
29	V	20	FEES,SUBSCRIPTIONS		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	2,980	2,980	29
30	V	21	CLERICAL & GENERAL		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	54,222	54,222	30
31	V	21	SALARIES-ACCTG-B. LARIMORE		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	3,343	3,343	31
32	V	24	EDUCATION & SEMINAR		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	360	360	32
33	V	26	INSURANCE		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	2	2	33
34	V	27	EMP. BEN.-GEN. ADMIN.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	25,999	25,999	34
35	V	30	DEPRECIATION		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	594	594	35
36	V	32	INTEREST		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	(7)	(7)	36
37	V	34	OFFICE RENT-UNRELATED		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	5,516	5,516	37
38	V	35	EQUIPMENT RENTAL		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	418	418	38
39	Total			$			$ 185,814	$ * 185,814	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	CORP ALLOC/MGMT FEE	157,838	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	$	$ (157,838)	15
16	V								16
17	V	6	REPAIRS AND MAINT.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%			17
18	V	7	EMP. BEN.-GEN. SERV.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%			18
19	V								19
20	V	1	DIETICIAN SALARIES	3,660	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	3,796	136	20
21	V	7	EMP. BEN.-GEN. ADMIN.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	844	844	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 161,498			$ 4,640	$ * (156,858)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	REHAB CONSULTING	$ 6,524	AT&R II, LLC	100.00%	$ 6,088	$ (436)	15
16	V	39	ANCILLARY REHAB	568,753	AT&R II, LLC	100.00%	530,760	(37,993)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 575,277			$ 536,848	$ * (38,429)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	REHAB CONSULTING	$ 3,454	Advanced Therapy and Rehab, LLC	100.00%	$ 2,980	$ (474)	15
16	V	39	ANCILLARY REHAB	304,798	Advanced Therapy and Rehab, LLC	100.00%	262,949	(41,849)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 308,252			$ 265,929	$ * (42,323)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	MEDICAL/TUBE FEED-MDCR	$ 40,892	QUALITY CARE MEDICAL SUPPLY	100.00%	$ 16,336	$ (24,556)	15
16	V	10	MEDICAL SUPPLIES	63,039	QUALITY CARE MEDICAL SUPPLY	100.00%	7,555	(55,484)	16
17	V	1	FOOD SUPPLEMENTS		QUALITY CARE MEDICAL SUPPLY	100.00%	17,629	17,629	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 103,931			$ 41,520	$ * (62,411)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	David Meisels	Owner	Administrative	45.00%	See Attached	5	9.10%		$		1
2	Brian Cloch	Owner	Administrative	45.00%	See Attached	11.03	16.97%	Alloc Quality	48,810	17-07	2
3	Brian Cloch	Owner	Administrative					Alloc Blvd HC	11,823	17-07	3
4	Brucha Teitelbaum	Owner	Administrative	10.00%	See Attached	1.42	3.55%	Alloc Quality	9,732	17-07	4
5	Joseph Meisels	Relative	Administrative	0%	See Attached	5.69	11.38%	Alloc Quality	4,004	17-07	5
6	Marilyn Cloch	Relative	Clerical	0%	See Attached	4.9	12.25%	Alloc Quality	3,619	21-07	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 77,988		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: QUALITY CARE MANAGEMENT
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	258,551	8	$ 7,246	$	52,342	$ 1,467	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	258,551	8	290		52,342	59	2
3	10	SAL-NURSING	PATIENT DAYS	258,551	8	103,396	103,396	52,342	20,932	3
4	10	NURS SAL-M. CLARKE	PATIENT DAYS	258,551	8	9,458	9,458	52,342	1,915	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	258,551	8	18,527		52,342	3,751	5
6	17	ADMIN SAL-NON-OWNER	PATIENT DAYS	258,551	8	148,217	148,217	52,342	30,006	6
7	17	ADMIN. SAL.- A. SALTZMAN	DIRECT/PATIENT DAYS		6	22,590	22,590		5,092	7
8	17	ADMIN. SAL - B BENOUDIZ	PATIENT DAYS	258,551	8	82,852	82,852	52,342	16,773	8
9	17	ADMIN. SAL. - B. CLOCH	PATIENT DAYS	258,551	8	217,962	217,962	52,342	44,125	9
10	17	ADMIN. SAL. - B. TEITELBAUM	DIRECT/PATIENT DAYS		5	22,566	22,566		6,413	10
11	17	ADMIN. SAL - J. MEISELS	DIRECT/PATIENT DAYS		5	9,284	9,284		2,638	11
12	17	ADMIN. SAL. - STEVE VAN CA	DIRECT/PATIENT DAYS		3	10,508	10,508			12
13	17	ADMIN. SAL. - MIKE FILIPPO	PATIENT DAYS	258,551	8	88,849	88,849	52,342	17,987	13
14	19	PROFESSIONAL FEES	PATIENT DAYS	258,551	8	36,541		52,342	7,397	14
15	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	258,551	8	35,917		52,342	7,271	15
16	21	CLERICAL & GENERAL	PATIENT DAYS	258,551	8	459,219	364,702	52,342	92,966	16
17	21	ACCTG SAL-B. LARIMORE	DIRECT/PATIENT DAYS		7	35,710	35,710		7,353	17
18	21	OFFICE SAL-M. CLOCH	PATIENT DAYS	258,551	8	17,876	17,876	52,342	3,619	18
19	24	EDUCATION & SEMINAR	PATIENT DAYS	258,551	8	1,028		52,342	208	19
20	26	INSURANCE	PATIENT DAYS	258,551	8	121		52,342	24	20
21	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	258,551	8	152,231		52,342	30,818	21
22	30	DEPRECIATION	PATIENT DAYS	258,551	8	77,371		52,342	15,663	22
23	32	INTEREST	PATIENT DAYS	258,551	8	19,022		52,342	3,851	23
24	34	OFFICE RENT-UNRELATED	PATIENT DAYS	258,551	8	59,175		52,342	11,980	24
25	TOTALS					$ 1,635,956	$ 1,133,970		$ 332,308	25

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: QUALITY CARE MANAGEMENT
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	35	EQUIPMENT RENTAL	PATIENT DAYS	258,551	8	$ 6,176	$	52,342	$ 1,250	1
2										2
3										3
4										4
5	6	REPAIRS AND MAINT.	PAINTING REVENUE	24,700	4	27,506	27,506	5,668	6,312	5
6	7	EMP. BEN.-GEN. SERV.	PAINTING REVENUE	24,700	4	4,515		5,668	1,036	6
7										7
8	1	DIETICIAN SALARIES	DIETICIAN REVENUE	34,652	8	42,478	42,478	10,208	12,513	8
9	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN REVENUE	34,652	8	6,973		10,208	2,054	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 87,648	$ 69,984		$ 23,165	25

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: QUALITY CARE MANAGEMENT
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMIN SAL-NON-OWNER	PATIENT DAYS	89,917	5	$ 5,150	$ 5,150	25,581	$ 1,465	1
2	17	ADMIN. SAL. - B. CLOCH	PATIENT DAYS	89,917	5	16,467	16,467	25,581	4,685	2
3	17	ADMIN. SAL. - B. TEITELBAUM	PATIENT DAYS	89,917	5	11,667	11,667	25,581	3,319	3
4	17	ADMIN. SAL - J. MEISELS	PATIENT DAYS	89,917	5	4,800	4,800	25,581	1,366	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	89,917	5	1,316		25,581	374	5
6	17	MGNT FEES-DIRECT ALLOC	DIRECT ALLOCATION		5	541,973			157,838	6
7	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	89,917	5	200		25,581	57	7
8	21	CLERICAL & GENERAL	PATIENT DAYS	89,917	5	55,820		25,581	15,881	8
9	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	89,917	5	1,825		25,581	519	9
10	30	DEPRECIATION	PATIENT DAYS	89,917	5	8,999		25,581	2,560	10
11	32	INTEREST	PATIENT DAYS	89,917	5	6,900		25,581	1,963	11
12	36	GAIN ON SALE OF ASSETS	PATIENT DAYS	89,917	5	(17,809)		25,581	(5,066)	12
13										13
14										14
15										15
16										16
17	1	DIETICIAN SALARIES	DIETICIAN REVENUE	4,053	3	3,527	3,527			17
18	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN REVENUE	4,053	3	71				18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 640,906	$ 41,611		$ 184,961	25

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: BOULEVARD HEALTHCARE MANAGEMEN
Street Address: 8950 GROSS POINT RD. SUITE 600
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	147,139	8	$ 2,034	$	25,581	$ 354	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	147,139	8	1,354		25,581	235	2
3	10	NURSING	PATIENT DAYS	147,139	8	6,902	5,142	25,581	1,200	3
4	10	SAL-NURSING-M. CLARKE	PATIENT DAYS	147,139	8	45,100	45,100	25,581	7,841	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	147,139	8	11,172		25,581	1,942	5
6	17	ADMIN SAL-NON-OWNER	PATIENT DAYS	147,139	8	101,666	101,666	25,581	17,675	6
7	17	ADMIN. SAL.- F. BENJAMIN	PATIENT DAYS	147,139	8	80,400	80,400	25,581	13,978	7
8	17	ADMIN. SAL - B BENOUDIZ	PATIENT DAYS	147,139	8	57,937	57,937	25,581	10,073	8
9	17	ADMIN. SAL. - B. CLOCH	PATIENT DAYS	147,139	8	68,004	68,004	25,581	11,823	9
10	17	ADMIN. SAL. - C. ROSS	DIRECT/PATIENT DAYS		4	4,050	4,050	25,581	1,401	10
11	17	ADMIN. SAL - S. VAN CAMP	PATIENT DAYS	147,139	8	50,000	50,000	25,581	8,693	11
12	17	ADMIN. SAL. - M. FILIPPO	PATIENT DAYS	147,139	8	61,604	61,604	25,581	10,710	12
13	17	ADMIN. SAL. - J. ELOWE	AVERAGE HOURS	10	3	12,210				13
14	19	PROFESSIONAL FEES	PATIENT DAYS	147,139	8	37,170		25,581	6,462	14
15	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	147,139	8	17,139		25,581	2,980	15
16	21	CLERICAL & GENERAL	PATIENT DAYS	147,139	8	311,878	242,119	25,581	54,222	16
17	21	SALARIES-ACCTG-B. LARIMO	DIRECT/PATIENT DAYS		7	17,000	17,000	25,581	3,343	17
18	24	EDUCATION & SEMINAR	PATIENT DAYS	147,139	8	2,070		25,581	360	18
19	26	INSURANCE	PATIENT DAYS	147,139	8	13		25,581	2	19
20	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	147,139	8	149,543		25,581	25,999	20
21	30	DEPRECIATION	PATIENT DAYS	147,139	8	3,414		25,581	594	21
22	32	INTEREST	PATIENT DAYS	147,139	8	(39)		25,581	(7)	22
23	34	OFFICE RENT-UNRELATED	PATIENT DAYS	147,139	8	31,727		25,581	5,516	23
24	35	EQUIPMENT RENTAL	PATIENT DAYS	147,139	8	2,402		25,581	418	24
25	TOTALS					$ 1,074,750	$ 733,022		$ 185,814	25

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: BOULEVARD HEALTHCARE MANAGEMEN
Street Address: 8950 GROSS POINT RD. SUITE 600
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3	6	REPAIRS AND MAINT.	PAINTING REVENUE	8,632	2	7,120	7,120			3
4	7	EMP. BEN.-GEN. SERV.	PAINTING REVENUE	8,632	2	1,583				4
5						$	$			5
6	1	DIETICIAN SALARIES	DIETICIAN REVENUE	19,790	8	20,524	20,524	3,660	3,796	6
7	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN REVENUE	19,790	8	4,564		3,660	844	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 33,791	$ 27,644		$ 4,640	25

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: AT&R II, LLC
Street Address: 8950 Gross Point Rd. #E
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847)663-1155
Fax Number: (847)663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10A	REHAB CONSULTING	DIRECT ALLOCATION						6,088	1
2	39	ANCILLARY REHAB	DIRECT ALLOCATION						530,760	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 536,848	25

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ADVANCED THERAPY AND REHAB, LLC
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847)663-1155
Fax Number: (847)663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10A	REHAB CONSULTING	DIRECT ALLOCATION						2,980	1
2	39	ANCILLARY REHAB	DIRECT ALLOCATION						262,949	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 265,929	25

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: QUALITY CARE MEDICAL SUPPLY
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847)663-1155
Fax Number: (847)663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	MEDICAL/TUBE FEED-MDCR	DIRECT ALLOCATION						16,336	1
2	10	MEDICAL SUPPLIES	DIRECT ALLOCATION						7,555	2
3	1	FOOD SUPPLEMENTS	DIRECT ALLOCATION						17,629	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 41,520	25

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Manufacturer's Bank		X	Working Capital	varies	5/28/98	900,000	262,572	demand	prm+1%	30,298	6
7	Yeshiva		X	Working Capital			800,000	800,000	demand	8.00%	64,019	7
8	Corus Bank		X	Working Capital	Int Only	7/15/98	1,500,000		demand	prm+.5%	60,959	8
9	TOTAL Facility Related						$ 3,200,000	$ 1,062,572			$ 155,276	9
	B. Non-Facility Related*											
10	See Supplemental Schedule						1,718,647	2,968,405			144,427	10
11	Interest Income		X								(652)	11
12												12
13												13
14	TOTAL Non-Facility Related						$ 1,718,647	$ 2,968,405			$ 143,775	14
15	TOTALS (line 9+line14)						$ 4,918,647	$ 4,030,977			$ 299,051	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	BANK LEUMI		X	WORKING CAPITAL	VARIES	5/24/00	$ 400,000	$ 226,863	06/01/03	PRM+.5%	$ 31,577	1
2	DVI		X	WORKING CAPITAL	VARIES			1,459,504		PRM+2%	24,113	2
3	HILL ROM		X	EQUIPMENT	1,554	5/1/00	18,647	0	05/01/01	10.00%	191	3
4	AIC CREDIT		X	INSURANCE	20,225	04/01/01	0	0	01/01/02	8.22%	6,081	4
5	VIASYS		X	EQUIPMENT	3,009	06/01/01	0	0	05/01/06	13.24%	8,342	5
6	CONTINENTAL CARE	X		WORKING CAPITAL	10,915	3/20/01	1,300,000	1,282,038	08/01/19	PRM+.5%	68,316	6
7	Allocation from Quality Care	X									5,814	7
8	Allocation from Boulevard HC	X									(7)	8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$ 1,718,647	$ 2,968,405			$ 144,427	21

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.		$ 175,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 171,706	2
3. Under or (over) accrual (line 2 minus line 1).		$ (3,294)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 180,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 176,706	7

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996		8
1997		9
1998	113,308	10
1999	169,114	11
2000	171,706	12

2001 accrual = 2000 actual tax x 1.05
171,706 x 1.05 = 180,291 (180,000 rounded)

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BLOOMINGDALE PAVILION COUNTY DUPAGE

FACILITY IDPH LICENSE NUMBER 0044347

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-23-124-022	NURSING HOME	$ 171,705.80	$ 171,705.80
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 171,705.80	$ 171,705.80

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 67,047 B. General Construction Type: Exterior MASONRY Frame _____ Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: ORGANIZATION COSTS, UNAMORTIZED LINE OF CREDIT
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9								-		-	9
10								-		-	10
11								-		-	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		-	-		-		-	68
69	Financial Statement Depreciation			79,271			(79,271)		69
70	TOTAL (lines 4 thru 69)		$	$ 79,271		$	$ (79,271)	$	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$	$ 79,271		$	$ (79,271)	$	1
2	HANDRAILS	1998	3,364		20	168	168	588	2
3	WALLPAPER	1998	3,542		20	177	177	620	3
4	WALLPAPER	1998	849		20	42	42	147	4
5	WIRING	1998	2,200		20	110	110	376	5
6	PULL STATION	1998	1,335		20	67	67	229	6
7	TILE	1998	821		20	41	41	140	7
8	CARPETING	1998	9,156		20	458	458	1,565	8
9	NURSES STATION	1998	9,819		20	491	491	1,637	9
10	WALLPAPER	1998	4,839		20	242	242	807	10
11	ELECTRICAL WORK	1998	2,265		20	113	113	367	11
12	CARPETING	1998	3,202		20	160	160	520	12
13	HAND RAILS	1998	11,299		20	565	565	1,836	13
14	CARPET INSTALL	1998	2,511		20	126	126	399	14
15	WALLPAPER	1998	2,166		20	108	108	342	15
16	ROOF REPAIRS	1998	3,595		20	180	180	555	16
17	EMERGENCY PANEL	1998	12,000		20	600	600	1,900	17
18	PAINTING & DECORATE	1998	5,985		20	299	299	922	18
19	FLOOR TILES	1998	1,740		20	87	87	261	19
20	FIRE ALARM WORK	1999	4,013		20	201	201	603	20
21	CARPETING	1999	3,218		20	161	161	483	21
22	FIRE DOOR	1999	1,348		20	67	67	190	22
23	FENCE	1999	1,705		20	85	85	220	23
24	ELEC OUTLETS	1999	635		20	32	32	83	24
25	AC COMPRESSOR	1999	3,286		20	164	164	424	25
26	OUTDOOR SHED	1999	1,277		20	64	64	155	26
27	FIRE ALARM WORK	1999	6,105		20	305	305	763	27
28	SHED MATERIALS	1999	1,357		20	68	68	159	28
29	COVE BASE	1999	701		20	35	35	82	29
30	WALLCOVERINGS	1999	962		20	48	48	112	30
31	WALLPAPER	1999	966		20	48	48	112	31
32	HAND RAILS	1999	15,358		20	768	768	1,792	32
33	WALLPAPER	1999	1,397		20	70	70	158	33
34	TOTAL (lines 1 thru 33)		$ 123,016	$ 79,271		$ 6,150	$ (73,121)	$ 18,547	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 123,016	$ 79,271		$ 6,150	$ (73,121)	$ 18,547	1
2	HANDRAILS	1999	15,358		20	768	768	1,728	2
3	WALLPAPER	1999	5,319		20	266	266	599	3
4	ELECTRICAL WORK	1999	985		20	49	49	106	4
5	GENERATOR WIRING	1999	709		20	35	35	76	5
6	FIRE ALARM SYSTEM	1999	5,500		20	275	275	642	6
7	WANDERGUARD MONITOR	1999	1,049		20	52	52	152	7
8	PAINTING & DEC	1999	3,049		20	152	152	380	8
9	GENERATOR REPAIRS	1999	1,346		20	67	67	156	9
10	FIBERGLASS WALLCOVER	1999	1,178		20	59	59	123	10
11	KEYPAD ENTRY SYSTEM	2000	5,146		20	257	257	1,286	11
12	FLOOR TILE	2000	1,074		20	54	54	81	12
13	FLOORING	2000	10,111		20	506	506	754	13
14	WALL COVERING	2000	1,180		20	118	118	354	14
15	BORDER	2000	834		20	42	42	209	15
16	SPRINKLER	2000	1,050		20	53	53	77	16
17	HANDRAIL	2000	2,000		20	100	100	140	17
18	BORDER	2000	507		20	25	25	127	18
19	WALLCOVERINGS	2000	1,179		20	59	59	295	19
20	ELECTRIC WIRING	2000	2,077		20	104	104	137	20
21	DOOR	2000	718		20	36	36	41	21
22	BOILER	2000	1,000		20	50	50	58	22
23	MIRRORS	2000	674		20	34	34	169	23
24	MIRRORS	2000	700		20	35	35	175	24
25	DOORS	2000	1,278		20	64	64	74	25
26	INTERCOM SYSTEM	2000	3,855		20	193	193	205	26
27	INST MIRRORS	2000	582		20	29	29	146	27
28	PAGING SYSTEM	2000	1,178		20	59	59	60	28
29	WINDOW TREATMENT	2000	1,474		20	74	74	74	29
30	INTERIOR SIGNAGE	2000	3,687		20	184	184	184	30
31	COMPRESSOR	2000	1,613		20	81	81	81	31
32	ROOFING	2000	525		20	26	26	26	32
33	CUBICLE CURTAINS	2000	515		20	26	26	26	33
34	TOTAL (lines 1 thru 33)		$ 200,466	$ 79,271		$ 10,082	$ (69,189)	$ 27,288	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 200,466	$ 79,271		$ 10,082	$ (69,189)	$ 27,288	1
2	COVE BASE	2000	829		20	41	41	41	2
3	WALLPAPER	2000	888		20	44	44	44	3
4	WALLCOVERING	2000	935		20	47	47	47	4
5	HEAT/COOL SYSTEM	2001	3,315		20	152	152	152	5
6	HEAT/COOL SYSTEM	2001	703		20	18	18	18	6
7	WATER HEATER	2001	2,992		20	75	75	75	7
8	REPIPE RANGE GUARD	2001	738		20	15	15	15	8
9	SPRINKLER SYSTEM REP	2001	4,850		20	101	101	101	9
10	SPRINKLER SYSTEM REP	2001	1,025		20	21	21	21	10
11	TRANSFORMER WORK	2001	5,259		20	66	66	66	11
12	HEAT/COOL SYSTEM	2001	777		20	3	3	3	12
13	ROOFING WORK	2001	4,000		20	17	17	17	13
14	TOILET	2001	692		20	29	29	29	14
15	A/C REPAIR	2001	576		20	17	17	17	15
16	A/C RECHARGE	2001	650		20	19	19	19	16
17	REPLACE COMPRESSOR	2001	524		20	15	15	15	17
18	REPR DOOR BRACKET	2001	529		20	11	11	11	18
19	DECORATE MAIN ENTRY	2001	2,055		20	43	43	43	19
20	SHEET FLOORING	2001	541		20	5	5	5	20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 232,344	$ 79,271		$ 10,821	$ (68,450)	$ 28,027	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 232,344	$ 79,271		$ 10,821	$ (68,450)	$ 28,027	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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19									19
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 232,344	$ 79,271		$ 10,821	$ (68,450)	$ 28,027	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 232,344	$ 79,271		$ 10,821	$ (68,450)	$ 28,027	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 232,344	$ 79,271		$ 10,821	$ (68,450)	$ 28,027	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 232,344	$ 79,271		$ 10,821	$ (68,450)	$ 28,027	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 232,344	$ 79,271		$ 10,821	$ (68,450)	$ 28,027	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 232,344	$ 79,271		$ 10,821	$ (68,450)	$ 28,027	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 232,344	$ 79,271		$ 10,821	$ (68,450)	$ 28,027	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 232,344	$ 79,271		$ 10,821	$ (68,450)	$ 28,027	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 232,344	$ 79,271		$ 10,821	$ (68,450)	$ 28,027	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
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23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$	$		$	$	$	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 383,493	$ 18,223	$ 41,127	$ 22,904	10	$ 135,400	71
72	Current Year Purchases	185,823	564	4,406	3,842	10	4,406	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 569,316	$ 18,787	$ 45,533	$ 26,746		$ 139,806	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 801,660	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 98,058	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 56,354	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (41,704)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 167,833	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: TRUST No. 10-30397-09

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		259	5/1/98	$ 1,144,623	13		3
4	Additions							4
5	Storage				4,224			5
6	Quality Care Mgmt & Blvd Allocations				17,496			6
7	TOTAL		259		$ 1,166,343 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: [X] YES [ ] NO Terms: AFTER 1/1/08, $17,612,000 *

10. Effective dates of current rental agreement:
Beginning 9/1/01
Ending 12/31/11

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$ 1,088,052
13.	/2003	$ 1,120,512
14.	/2004	$ 1,153,776

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 24,027 Description: See attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 81,905	$		$ 81,905	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			42,852			42,852	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			755,405			755,405	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 03	# of prescrpts			29,760	222,363		252,123	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39 - 01		312,047					312,047	12
13	Other (specify):					188,029	402,864		590,893	13
14	TOTAL			$ 312,047		$ 1,097,951	$ 625,227		$ 2,035,225	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (138,653)	$	1
2	Cash-Patient Deposits	60,089		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,062,507		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	83,468		6
7	Other Prepaid Expenses	39,099		7
8	Accounts Receivable (owners or related parties)	3,266		8
9	Other(specify): See supplemental schedule	263,876		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,373,652	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	201,961		15
16	Equipment, at Historical Cost	478,459		16
17	Accumulated Depreciation (book methods)	(264,344)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	1,218,818		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,634,894	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,008,546	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,184,229	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	60,089		28
29	Short-Term Notes Payable	4,030,977		29
30	Accrued Salaries Payable	247,334		30
31	Accrued Taxes Payable (excluding real estate taxes)	26,920		31
32	Accrued Real Estate Taxes(Sch.IX-B)	180,000		32
33	Accrued Interest Payable	38,041		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	72,476		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,840,066	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,840,066	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,831,520)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,008,546	$	48

*(See instructions.)

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,055,982)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,055,982)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(775,538)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (775,538)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,831,520)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,178,330	1
2	Discounts and Allowances for all Levels	(2,901,806)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,276,524	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,818,163	6
7	Oxygen	319,363	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,137,526	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	28,210	10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	577,823	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	111,481	19
20	Radiology and X-Ray	11,743	20
21	Other Medical Services	377,184	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,106,441	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	652	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 652	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,521,143	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,555,130	31
32	Health Care	5,228,967	32
33	General Administration	2,429,315	33
	B. Capital Expense		
34	Ownership	1,801,102	34
	C. Ancillary Expense		
35	Special Cost Centers	2,140,364	35
36	Provider Participation Fee	141,803	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,296,681	40
41	**Income before Income Taxes (line 30 minus line 40)****	(775,538)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (775,538)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? no If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,975	2,207	$ 74,750	$ 33.87	1
2	Assistant Director of Nursing	2,325	2,830	65,317	23.08	2
3	Registered Nurses	60,270	82,153	1,662,434	20.24	3
4	Licensed Practical Nurses	15,654	18,180	364,540	20.05	4
5	Nurse Aides & Orderlies	126,911	188,485	1,703,463	9.04	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	14,372	16,358	312,047	19.08	7
8	Rehab/Therapy Aides	8,442	9,844	132,967	13.51	8
9	Activity Director	3,296	3,920	63,785	16.27	9
10	Activity Assistants	10,989	12,660	130,314	10.29	10
11	Social Service Workers	5,893	6,714	96,177	14.32	11
12	Dietician					12
13	Food Service Supervisor	4,069	4,166	64,984	15.60	13
14	Head Cook					14
15	Cook Helpers/Assistants	28,885	31,955	273,072	8.55	15
16	Dishwashers					16
17	Maintenance Workers	5,281	5,850	91,299	15.61	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,924	2,085	86,949	41.70	20
21	Assistant Administrator	1,833	2,278	60,278	26.46	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,196	13,447	190,074	14.14	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,292	3,738	50,136	13.41	31
32	Other Health Care(specify)					32
33	Other(specify)	72	80	1,979	24.74	33
34	TOTAL (lines 1 - 33)	307,679	406,950	$ 5,424,565 *	$ 13.33	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	462	$ 13,868	01-03	35
36	Medical Director	219	28,375	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	216	7,560	10-03	39
40	Physical Therapy Consultant	115	5,310	10a-03	40
41	Occupational Therapy Consultant	99	4,669	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	2,632	11-03	44
45	Social Service Consultant	46	2,070	12-03	45
46	Other(specify)				46
47	Wound Care	22	2,750	10-03	47
48					48
49	TOTAL (lines 35 - 48)	1,227	$ 67,234		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	10,055	$ 431,950	10-03	50
51	Licensed Practical Nurses	2,398	91,208	10-03	51
52	Nurse Aides	3,587	80,496	10-03	52
53	TOTAL (lines 50 - 52)	16,040	$ 603,654		53

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
William Pfeiffer	Administrator	0	$ 86,949
Aimee Musial	Asst. Admin	0	60,278
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 147,227

B. Administrative - Other

Description	Amount
Quality Care Management - corporate allocation	$ 561,521
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 561,521

C. Professional Services

Vendor/Payee	Type	Amount
Sachnoff & Weaver	Legal	$ 19,393
Winston & Strawn	Legal	16,302
Walinski & Truncket	Legal	425
Frost, Ruttenberg & Rothblatt	Accounting	20,895
Zimmerman Associates	Real Estate Consultant	450
See attached	Computer services	20,409
Personnel Planners	Unemployment Consult	1,129
Systematic Management Syst	Glucose billing	4,483
LTC Associates	IOC consultant	3,364
Documentation Solutions	A/R Consulting	508
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 87,358

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 94,774
Unemployment Compensation Insurance	67,954
FICA Taxes	406,354
Employee Health Insurance	134,799
Employee Meals	32,850
Illinois Municipal Retirement Fund (IMRF)*	
401K EXPENSE	29,589
EMPLOYEE BENEFITS	48,572
HOLIDAY EXPENSE	3,222
TOTAL (agree to Schedule V, line 22, col.8)	$ 818,114

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	8,313
Health Care Worker Background Check	1,000
(Indicate # of checks performed 83)	
ADVERTISING & PROMOTION	46,967
DUES & SUBSCRIPTIONS	9,960
Allocations Quality Care & Blvd	10,308
LICENSES, PERMITS & FEES	1,462
EMPLOYEE RECRUITMENT	13,997
YELLOW PAGE ADS	14,413
Less: Public Relations Expense	
Non-allowable advertising	(46,967)
Yellow page advertising	(14,413)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 45,440

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,697
Allocation Blvd Hlthcare Mgmt	360
Allocation Quality Care	208
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,265

**See instructions.

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	none		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number BLOOMINGDALE PAVILION # 0044347 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL - 13,260

(3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YEARS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 5,907 Line 10-2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 141,803
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 32,850 Has any meal income been offset against related costs? N/A Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 100% In 14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees